		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039834

Facility Name: JACKSON SQUARE NURSING & REHAB CENTER

Address: 5130 W JACKSON BLVD (Number) CHICAGO (City) 60644 (Zip Code)

County: COOK

Telephone Number: (773) 921-8000 **Fax #** (773) 921-3980

IDPA ID Number: 363961688001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	234	TOTALS	234	85,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	67,681	1,449	7,905	77,035	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,681	1,449	7,905	77,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.19%

D. How many bed-hold days during this year were paid by Public Aid?
2,368 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 66 and days of care provided 5,803

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB (# 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	271,224	120,220	13,611	405,055		405,055		405,055			1
2	Food Purchase		362,006		362,006	(17,947)	344,059	(68)	343,991			2
3	Housekeeping		48,024	343,200	391,224		391,224		391,224			3
4	Laundry		30,731		30,731		30,731		30,731			4
5	Heat and Other Utilities			240,459	240,459		240,459	611	241,070			5
6	Maintenance	92,539	24,107	169,668	286,314		286,314	850	287,164			6
7	Other (specify):*							(77)	(77)			7
8	**TOTAL General Services**	363,763	585,088	766,938	1,715,789	(17,947)	1,697,842	1,316	1,699,158			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,630,365	156,003	33,652	2,820,020		2,820,020	(7,968)	2,812,052			10
10a	Therapy	100,365		9,151	109,516		109,516		109,516			10a
11	Activities	80,135	8,291	2,444	90,870		90,870		90,870			11
12	Social Services	103,935		2,413	106,348		106,348		106,348			12
13	Nurse Aide Training	1,245		671	1,916		1,916		1,916			13
14	Program Transportation			241	241		241	936	1,177			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,916,045	164,294	70,172	3,150,511		3,150,511	(7,032)	3,143,479			16
	C. General Administration											
17	Administrative	140,438		701,974	842,412		842,412	(597,399)	245,013			17
18	Directors Fees											18
19	Professional Services			93,872	93,872		93,872	(4,349)	89,523			19
20	Dues, Fees, Subscriptions & Promotions			61,393	61,393		61,393	(32,472)	28,921			20
21	Clerical & General Office Expenses	111,279	26,299	261,663	399,241		399,241	(93,672)	305,569			21
22	Employee Benefits & Payroll Taxes			586,158	586,158	17,947	604,105		604,105			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,346	10,346		10,346	(3,527)	6,819			24
25	Other Admin. Staff Transportation			912	912		912	158	1,070			25
26	Insurance-Prop.Liab.Malpractice			276,308	276,308		276,308	646	276,954			26
27	Other (specify):*							32,663	32,663			27
28	**TOTAL General Administration**	251,717	26,299	1,992,626	2,270,642	17,947	2,288,589	(697,952)	1,590,637			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,531,525	775,681	2,829,736	7,136,942		7,136,942	(703,668)	6,433,274			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER #0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			133,763	133,763		133,763	84,775	218,538			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,099	38,099		38,099	844,702	882,801			32
33	Real Estate Taxes			339,908	339,908		339,908	(16,526)	323,382			33
34	Rent-Facility & Grounds			1,453,259	1,453,259		1,453,259	(1,443,079)	10,180			34
35	Rent-Equipment & Vehicles			9,272	9,272		9,272	8,720	17,992			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,974,301	1,974,301		1,974,301	(521,408)	1,452,893			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	14,868	96,968	349,191	461,027		461,027	235	461,262			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,115	128,115		128,115		128,115			42
43	Other (specify):*	44,993			44,993		44,993	(44,993)				43
44	**TOTAL Special Cost Centers**	59,861	96,968	477,306	634,135		634,135	(44,758)	589,377			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,591,386	872,649	5,281,343	9,745,378		9,745,378	(1,269,834)	8,475,544			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	80,612	30		9
10	Interest and Other Investment Income	(1,126)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(498)	21		18
19	Entertainment	(4,850)	24		19
20	Contributions	(19,449)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(218,112)	21		24
25	Fund Raising, Advertising and Promotional	(12,493)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,183)	20		28
29	Other-Attach Schedule	(96,079)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (275,246)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(994,588)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (994,588)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,269,834)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
JACKSON SQUARE NURSING & REHAB CENTER

ID# 0039834
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE Dues	$ (3,868)	20	1
2	Bank Charges	(14,204)	21	2
3	Pharmacy - Veterans	(7,968)	10	3
4	Non-Allowable Legal Expense	(7,042)	19	4
5	Non-Allowed Nucare Salary	(1,361)	21	5
6	Non-Allowed Payroll Taxes	(117)	27	6
7	Marketing Salary	(44,993)	43	7
8	Real Estate Tax Offset	(16,526)	33	8
9				9
10				10
11				11
12				12
13				13
14				14
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100				100
101	Total	(96,079)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(68)											(68)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			611									611	5
6	Maintenance			850									850	6
7	Other (specify):*			(77)									(77)	7
8	**TOTAL General Services**	(68)		1,384									1,316	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(7,968)											(7,968)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			936									936	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(7,968)		936									(7,032)	16
	C. General Administration													
17	Administrative			(640,856)	67,788	(24,331)							(597,399)	17
18	Directors Fees													18
19	Professional Services	(7,042)		1,274		1,419							(4,349)	19
20	Fees, Subscriptions & Promotions	(38,993)		1,175		5,346							(32,472)	20
21	Clerical & General Office Expenses	(234,175)		136,986		3,517							(93,672)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(4,850)		1,289		34							(3,527)	24
25	Other Admin. Staff Transportation			158									158	25
26	Insurance-Prop.Liab.Malpractice			646									646	26
27	Other (specify):*	(117)		21,052	3,811	7,917							32,663	27
28	**TOTAL General Administration**	(285,177)		(478,276)	71,599	(6,098)							(697,952)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(293,213)		(475,956)	71,599	(6,098)							(703,668)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	80,612		4,163									84,775	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,126)	846,318	(490)									844,702	32
33	Real Estate Taxes	(16,526)											(16,526)	33
34	Rent-Facility & Grounds		(1,453,259)	10,180									(1,443,079)	34
35	Rent-Equipment & Vehicles			8,720									8,720	35
36	Other (specify):*													36
37	TOTAL Ownership	62,960	(606,941)	22,573									(521,408)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			235									235	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(44,993)											(44,993)	43
44	TOTAL Special Cost Centers	(44,993)		235									(44,758)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(275,246)	(606,941)	(453,148)	71,599	(6,098)							(1,269,834)	45

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,453,259	Jackson Square Associates		$	$ (1,453,259)	1
2	V	32	Interest Expense		Jackson Square Associates		846,318	846,318	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,453,259			$ 846,318	$ * (606,941)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 611	$ 611	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.		850	850	16
17	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.		(77)	(77)	17
18	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.		936	936	18
19	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.		3,098	3,098	19
20	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.		1,274	1,274	20
21	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.		1,175	1,175	21
22	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.		136,986	136,986	22
23	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.		1,289	1,289	23
24	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.		158	158	24
25	V	26	INSURANCE		NUCARE SERVICES CORP.		646	646	25
26	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.		21,052	21,052	26
27	V	30	DEPRECIATION		NUCARE SERVICES CORP.		4,163	4,163	27
28	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.		(490)	(490)	28
29	V	34	BUILDING RENT		NUCARE SERVICES CORP.		10,180	10,180	29
30	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.		8,720	8,720	30
31	V	39	ANCILLARY		NUCARE SERVICES CORP.		235	235	31
32	V								32
33	V	17	MANAGEMENT FEES	643,954	NUCARE SERVICES CORP.			(643,954)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 643,954			$ 190,806	$ * (453,148)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 20,420	$ 20,420	15
16	V	17	ADMIN. - R. BOTTNER		NUCARE SERVICES CORP.	100.00%	24,691	24,691	16
17	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	20,781	20,781	17
18	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,896	1,896	18
19	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			19
20	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,794	1,794	20
21	V	27	EMP. BEN. - R. BOTTNER		NUCARE SERVICES CORP.	100.00%	963	963	21
22	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	906	906	22
23	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	148	148	23
24	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 71,599	$ * 71,599	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 33,689	$ 33,689	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	1,419	1,419	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	5,346	5,346	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	3,517	3,517	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	34	34	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	7,917	7,917	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	58,020	CAREPATH HEALTH NETWORK	100.00%		(58,020)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 58,020			$ 51,922	$ * (6,098)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	$ 50,771	Diamond Insurance	20.00%	$ 50,771	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 50,771			$ 50,771	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Hartman	Relative	Administrative		See Attached	0.6	1.31%	Alloc-NuCare	$ 1,896	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	5.1	8.50%	Alloc-NuCare	20,781	17-7	2
3	Robert Hartman	Owner	Administrative	60.75%	See Attached	4.23	6.50%	Alloc-NuCare	20,420	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,097		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	752,896	9	$ 5,390	$	85,410	$ 611	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	752,896	9	7,491	(2,814)	85,410	850	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	752,896	9	(678)		85,410	(77)	3
4	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	752,896	9	8,255		85,410	936	4
5	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	752,896	9	27,305	23,542	85,410	3,098	5
6	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	752,896	9	11,230		85,410	1,274	6
7	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	752,896	9	10,356		85,410	1,175	7
8	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	752,896	9	1,207,546	985,408	85,410	136,986	8
9	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	752,896	9	11,367		85,410	1,289	9
10	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	752,896	9	1,396		85,410	158	10
11	26	INSURANCE	AVAIL. CENSUS DAYS	752,896	9	5,696		85,410	646	11
12	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	752,896	9	185,578		85,410	21,052	12
13	30	DEPRECIATION	AVAIL. CENSUS DAYS	752,896	9	36,699		85,410	4,163	13
14	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	752,896	9	(4,322)		85,410	(490)	14
15	34	BUILDING RENT	AVAIL. CENSUS DAYS	752,896	9	89,738		85,410	10,180	15
16	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	752,896	9	76,871		85,410	8,720	16
17	39	ANCILLARY	AVAIL. CENSUS DAYS	752,896	9	2,070	1,668	85,410	235	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,681,988	$ 1,007,804		$ 190,806	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	37	9	180,000	720,000	4	20,420	1
2	17	ADMIN. - R. BOTTNER	AVG. HOURS WORKED	50	9	217,649	215,000	6	24,691	2
3	17	ADMIN. - B. CARR	AVG. HOURS WORKED	45	9	183,358	181,000	5	20,781	3
4	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	6	9	18,016	17,000	1	1,896	4
5	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35	1	18,973	17,000			5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	37	9	15,814		4	1,794	6
7	27	EMP. BEN. - R. BOTTNER	AVG. HOURS WORKED	50	9	8,491		6	963	7
8	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	45	9	7,998		5	906	8
9	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	6	9	1,411		1	148	9
10	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35	1	1,411				10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 653,121	$ 1,150,000		$ 71,599	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	617,442	13	$ 358,512	$ 358,512	58,020	$ 33,689	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	617,442	13	15,097		58,020	1,419	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	617,442	13	56,887		58,020	5,346	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	617,442	13	37,424		58,020	3,517	4
5	24	SEMINARS	CARE PATH FEES	617,442	13	365		58,020	34	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	617,442	13	84,255		58,020	7,917	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 552,540	$ 358,512		$ 51,922	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd., Suite 105
City / State / Zip Code: Northbrook, IL 60062
Phone Number: ((847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Diamond Insurance	Direct Allocation			$	$		$ 50,771	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 50,771	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB (# 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Jackson Square Associates	X					$	$			$ 846,318	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	Int. Only			1,000,000	7/01 Ann.		38,099	6
7									Renewal			7
8												8
9	TOTAL Facility Related						$	$ 1,000,000			$ 884,417	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest Income										(1,126)	11
12	Allocated from Nucare	X									(490)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,616)	14
15	TOTALS (line 9+line14)						$	$ 1,000,000			$ 882,801	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB C] # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		$ 173,291	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 331,096	2
3. Under or (over) accrual (line 2 minus line 1).		$ 157,805	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 182,103	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 168,795 For 94-99 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (16,526)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 323,382	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	315,547	8
	1998	327,354	9
	1999	325,157	10
	2000	322,703	11
	2001	331,096	12

Accrual: $331,096 X 1.05 = 347,651
Less prepayment of 3/03 installment of $165,548
Restatement of beginning R.E. Accrual by $4196 = PY accrual included escrow & accrual

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSON SQUARE NURSING & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-209-002-0000	Long Term Care Property	$ 331,096.03	$ 331,096.06
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 331,096.03	$ 331,096.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSON SQUARE NURSING & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior Brick Frame Brick/Concrete Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medical Clinic - Costs are not included on Page 3 or 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	89,364	1987	$ 71,619	1
2					2
3	TOTALS	89,364		$ 71,619	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	198,972		20	9,949	9,949	19,898	9
10	Various			1988	17,097		20	854	854	1,708	10
11	Various			1989	19,023		20	952	952	1,904	11
12	Various			1990	33,869		20	1,693	1,693	3,386	12
13	Various			1991	10,518		20	526	526	1,052	13
14	Various			1993	3,315		20	166	166	332	14
15	Various			1994	110,244		20	5,512	5,512	13,035	15
16	Various			1995	57,890		20	2,896	2,896	21,795	16
17	Various			1996	130,269		20	6,515	6,515	42,321	17
18	Various			1997	128,018		20	6,497	6,497	34,807	18
19	Various			1998	35,115		20	1,756	1,756	7,952	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		3,175,746	108		95,385	95,277	1,429,639	68
69	Financial Statement Depreciation			65,818			(65,818)		69
70	TOTAL (lines 4 thru 69)		$ 3,920,076	$ 65,926		$ 132,701	$ 66,775	$ 1,577,829	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,920,076	$ 65,926		$ 132,701	$ 66,775	$ 1,577,829	1
2	SUBMERSIBLE PUMP	1999	2,325		20	116	116	464	2
3	ALARM KEYPADS	1999	1,071		20	54	54	207	3
4	TIMER/MONITOR	1999	803		20	40	40	153	4
5	WATER CONDITIONER	1999	4,050		20	203	203	761	5
6	WINDOW SCREENS	1999	1,038		20	52	52	195	6
7	ROOF FLASHING	1999	1,200		20	60	60	215	7
8	MONITOR/TELEPHONE	1999	644		20	32	32	117	8
9	BLINDS	1999	724		20	36	36	129	9
10	INSTALL DRAIN TILE	1999	4,575		20	229	229	802	10
11	WALLPAPER	1999	732		20	37	37	133	11
12	TILES	1999	659		20	33	33	116	12
13	GENERATOR	1999	440		20	22	22	84	13
14	DOOR RESTRICTORS	1999	4,758		20	238	238	833	14
15	TILES	1999	618		20	31	31	106	15
16	TANK REPAIRS	1999	1,463		20	73	73	243	16
17	DRYWALL/PAINT	1999	17,800		20	890	890	2,967	17
18	FENCE	1999	2,600		20	130	130	423	18
19	DOOR/FRAME	1999	543		20	27	27	86	19
20	CLOSED CIRCUIT TV SY	1999	2,742		20	137	137	422	20
21	NEW CHIMES	1999	954		20	48	48	188	21
22	PULLSTATIONS	1999	390		20	20	20	68	22
23	NURSES CALL SYS	1999	216		20	11	11	34	23
24	GENERATOR RPR	1999	6,259		20	313	313	1,069	24
25	HOT WATER TANKS	1999	500		20	25	25	77	25
26	REPAIR EMERGENCY PAN	1999	1,714		20	86	86	344	26
27	REPAIR ELEVATOR CAB	1999	3,014		20	151	151	604	27
28	TILES	1999	1,127		20	56	56	219	28
29	PUMP REPAIR	1999	575		20	29	29	114	29
30	DOOR RESTRICTORS	1999	1,432		20	72	72	234	30
31	SAFETY EDGE	1999	1,600		20	80	80	260	31
32	LIGHT FIXTURES	1999	559		20	28	28	86	32
33	REPAIR DOOR LOCK REP	2000	610		20	31	31	93	33
34	TOTAL (lines 1 thru 33)		$ 3,987,811	$ 65,926		$ 136,091	$ 70,165	$ 1,589,675	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,987,811	$ 65,926		$ 136,091	$ 70,165	$ 1,589,675	1
2	FRT - INSTALL ICU	2000	1,700		20	85	85	255	2
3	INSTALL NEW COMPRESS	2000	16,764		20	838	838	2,444	3
4	INSTALL 78 OVER BD L	2000	13,820		20	691	691	2,015	4
5	5 DINING GARBAGE CAB	2000	1,250		20	63	63	137	5
6	3RD FLR NURSING STAT	2000	11,600		20	580	580	1,692	6
7	WROUGHT IRON FENCE	2000	1,065		20	53	53	155	7
8	INSTALL CCTV MONITOR	2000	3,372		20	169	169	493	8
9	INSTALL 1-600 TANK	2000	28,500		20	1,425	1,425	4,156	9
10	INSTALL VOLTAGE COIL	2000	945		20	47	47	106	10
11	HOOK UPS DIALYSIS MA	2000	24,200		20	1,210	1,210	3,428	11
12	INSTALL WINDOW TREAT	2000	75		20	4	4	10	12
13	3' BRASS OVERBED LIG	2000	5,786		20	289	289	819	13
14	REPAIR BALLASTS AN	2000	906		20	45	45	128	14
15	CHILLER PARTS	2000	4,050		20	203	203	575	15
16	CEILING TILES	2000	846		20	42	42	119	16
17	CEILING TILES	2000	628		20	31	31	88	17
18	FURNISH AND INSTALLS	2000	2,024		20	101	101	286	18
19	GENERATOR BATTERY	2000	1,348		20	67	67	184	19
20	FURNISH AND INSTALL	2000	896		20	45	45	124	20
21	ENCLOSE 2 SMOKING LG	2000	26,130		20	1,307	1,307	3,594	21
22	INSTALL REMOTE MULTI	2000	1,672		20	84	84	231	22
23	INSTALL TELEPHON	2000	440		20	22	22	61	23
24	10 MONTHS TANK RENTL	2000	5,000		20	250	250	688	24
25	10 MNTHS TANK RNTL &	2000	5,460		20	273	273	751	25
26	START UP REPLACEMNT	2000	252		20	13	13	36	26
27	WALL PAPER & BORDER	2000	1,204		20	60	60	160	27
28	REPAIR REMOTE WIRING	2000	4,157		20	208	208	555	28
29	2 MOTOR SYSTEMS	2000	174		20	9	9	24	29
30	REKEY DIETARY DEPT	2000	1,387		20	69	69	184	30
31	CABLEING FOR COMPUTE	2000	686		20	34	34	88	31
32	BOILER REPAIRS	2000	7,300		20	365	365	973	32
33	SAFETY SLIDE RAILS	2000	3,371		20	169	169	451	33
34	TOTAL (lines 1 thru 33)		$ 4,164,819	$ 65,926		$ 144,942	$ 79,016	$ 1,614,685	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,164,819	$ 65,926		$ 144,942	$ 79,016	$ 1,614,685	1
2	FURNISH & INSTALL	2000	735		20	37	37	96	2
3	FURNISH & INSTALL	2000	686		20	34	34	88	3
4	CARPETING	2000	2,949		20	147	147	355	4
5	VENTS	2000	1,284		20	64	64	155	5
6	FAUCET & REPAIR KIT	2000	697		20	35	35	85	6
7	REPAIR COMPRESSOR	2000	3,730		20	187	187	452	7
8	FLORESENT LIGHTIN	2000	967		20	48	48	112	8
9	ADJUST CONTROL PANEL	2000	526		20	26	26	69	9
10	INSTALL ELECTRIC DOO	2000	1,635		20	82	82	191	10
11	RAN PHONE LINES	2000	869		20	43	43	100	11
12	FIRE DAMPERS FOR VEN	2000	5,350		20	268	268	581	12
13	SERVICE PA SYSTEM	2000	1,160		20	58	58	126	13
14	INSTALL CCTV & VCR	2000	1,965		20	98	98	212	14
15	CEILING TILES	2000	694		20	35	35	76	15
16	LINEN CHUTES DOOR	2000	520		20	26	26	54	16
17	LIGHT FIXTURE COVERS	2000	826		20	41	41	85	17
18	CEILING TILE	2000	715		20	36	36	75	18
19	INSTALL CONTRACTO	2000	2,970		20	149	149	323	19
20	TANK REMOVAL	2000	2,914		20	146	146	438	20
21	PAINTING/DECORATING	2000	2,601		20	130	130	271	21
22	FIRE DAMPERS	2001	867		20	43	43	82	22
23	GENERATOR REPAIR	2001	1,136		20	57	57	109	23
24	SECURITY SYSTEM UPGR	2001	956		20	48	48	88	24
25	MAGNETIC DOOR HOLDER	2001	975		20	49	49	90	25
26	ELEVATOR CONTRLR UNT	2001	2,000		20	100	100	175	26
27	MAGNETIC DOOR HOLDER	2001	952		20	48	48	80	27
28	PHONE LINE INSTALLAT	2001	994		20	50	50	83	28
29	ELEVATOR REAPIR	2001	742		20	37	37	59	29
30	EXIT SIGNS	2001	547		20	27	27	43	30
31	MYERS PUMP	2001	1,261		20	63	63	95	31
32	ELEVATOR CONTRLR UNT	2001	2,598		20	130	130	184	32
33	SECURITY UPGRADES	2001	4,359		20	218	218	327	33
34	TOTAL (lines 1 thru 33)		$ 4,215,999	$ 65,926		$ 147,502	$ 81,576	$ 1,620,044	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,215,999	$ 65,926		$ 147,502	$ 81,576	$ 1,620,044	1
2	LIGHT FIXTURES	2001	2,223		20	111	111	157	2
3	WATER FAUCETS	2001	1,361		20	68	68	91	3
4	DOOR LOCKS	2001	728		20	36	36	48	4
5	MAGNETIC DOOR HOLDER	2001	1,424		20	71	71	83	5
6	EXIT SIGNS	2001	613		20	31	31	36	6
7	EXIT SIGNS	2001	721		20	36	36	42	7
8	DOOR LOCKS	2001	1,646		20	82	82	137	8
9	REPLACE BOILER	2002	3,975		20	397	397	397	9
10	EXIT SIGNS ON 3RD AND 4TH FL.	2002	1,537		20	141	141	154	10
11	CLOSED CIRCUIT TV SYSTEM	2002	1,407		20	129	129	141	11
12	ALARM SYSTEM (SERV/UPGRADE)	2002	1,358		20	136	136	136	12
13	INSTALL MAGENETIC DOOR HOLDERS	2002	1,424		20	119	119	119	13
14	INSTALL CLOSED CIRC. TV SYS.	2002	1,418		20	118	118	118	14
15	INSTALL ALARM SYSTEM	2002	1,334		20	78	78	78	15
16	CLOSED CIRCUIT TV SYSTEM	2002	4,186		20	244	244	244	16
17	INSTALLED GLASS AND SKYLIGHT	2002	1,795		20	120	120	120	17
18	115 volt FAN	2002	980		20	41	41	41	18
19	INSIDE AWNINGS	2002	1,117		20	37	37	37	19
20	AWNING FOR BACK DOOR/PATIO	2002	2,025		20	68	68	68	20
21	LANDSCAPING	2002	14,800		20	493	493	493	21
22	RESURFACE PK. LOT/ SIDEWALK	2002	37,041		20	1,235	1,235	1,235	22
23	CCTV SYSTEM	2002	2,858		20	119	119	119	23
24	CCTV SYSTEM	2002	1,953		20	81	81	81	24
25	CCTV SYSTEM	2002	1,706		20	57	57	57	25
26	SUPPLIES TO INSTALL OVERBED LIGHTS	2002	914		20	23	23	23	26
27	CCTV SYSTEM RECORDER	2002	1,410		20	35	35	35	27
28	78 OVERBED LIGHT FIXTURES	2002	5,616		20	140	140	140	28
29	INSTALLED ELCTROMAGNET DOOR HOLDERS	2002	1,446		20	24	24	24	29
30	SERVICE ON CCTV	2002	1,298		20	22	22	22	30
31	ADDITIONAL TRIP CHARGES	2002	2,300		20	77	77	77	31
32	20 OVERBED LIGHT FIXTURES	2002	1,440		20	12	12	12	32
33	SERVICE ON CCTV	2002	1,106		20	83	83	111	33
34	TOTAL (lines 1 thru 33)		$ 4,321,159	$ 65,926		$ 151,966	$ 86,040	$ 1,624,720	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,321,159	$ 65,926		$ 151,966	$ 86,040	$ 1,624,720	1
2	SERVICE ON CCTV	2002	910		20	68	68	91	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	1
2									2
3									3
4									4
5									5
6									6
7									7
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	1
2									2
3									3
4									4
5									5
6									6
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,322,069	$ 65,926		$ 152,034	$ 86,108	$ 1,624,811	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1987	1980	$ 3,173,042	$	35	$ 95,250	$ 95,250	$ 1,429,167	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated Nucare			1997	522	13	20	26	13	137	9
10	Allocated Nucare			1998	458	12	20	23	11	102	10
11	Allocated Nucare			1999	642	55	20	32	(23)	110	11
12	Allocated Nucare			2000	780	20	20	39	(19)	95	12
13	Allocated Nucare			2001	302	8	20	15	7	28	13
14											14
15											15
16											16
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31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,175,746	$ 108		$ 95,385	$ 95,239	$ 1,429,639	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTE # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 580,149	$ 70,343	$ 58,401	$ (11,942)	10	$ 235,992	71
72	Current Year Purchases	118,026	1,515	7,961	6,446	10	7,961	72
73	Fully Depreciated Assets	22,896	140	140		10	22,896	73
74								74
75	TOTALS	$ 721,071	$ 71,998	$ 66,502	$ (5,496)		$ 266,849	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1992 FORD VAN	1990	$ 2,282	$	$	$	5	$	76
77										77
78										78
79										79
80	TOTALS			$ 2,282	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,117,041	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,924	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 218,536	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 80,612	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,891,660	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Nucare				10,180			5
6								6
7	TOTAL				$ 10,180 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 10,851 Description: Copy Machine $2131; Allocation Nucare $8720
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	2001 Lexus RX300	$ 593.00	$ 7,141	17
18					18
19					19
20					20
21	TOTAL		$ 593.00	$ 7,141	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 570	$	$ 570
2	Books and Supplies		100		100
3	Classroom Wages (a)				
4	Clinical Wages (b)		1,246		1,246
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,916	$	$ 1,916
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,916			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 57,158	$		$ 57,158	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,063			27,063	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			60,494			60,494	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			204,476	28,483		232,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			14,868			68,485		83,353	13
14	TOTAL			$ 14,868		$ 349,191	$ 96,968		$ 461,027	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,386	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,856,657		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	152,942		6
7	Other Prepaid Expenses	11,271		7
8	Accounts Receivable (owners or related parties)	755,361		8
9	Other(specify): See Supplemental Schedule	12,449		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,791,066	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	773,584		15
16	Equipment, at Historical Cost	626,455		16
17	Accumulated Depreciation (book methods)	(676,917)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	54,080		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 777,202	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,568,268	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 754,751	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,960		28
29	Short-Term Notes Payable	1,000,000		29
30	Accrued Salaries Payable	217,356		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,033		31
32	Accrued Real Estate Taxes(Sch.IX-B)	182,103		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	34,672		35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	556,435		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,781,310	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,781,310	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,786,958	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,568,268	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,254,056	1
2	Restatements (describe):		2
3	See Supplemental Schedule	(549,653)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,704,403	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	82,555	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 82,555	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,786,958	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENT # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,840,541	1
2	Discounts and Allowances for all Levels	(221,745)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,618,796	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	464,467	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 464,467	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	118,209	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57,833	19
20	Radiology and X-Ray		20
21	Other Medical Services	395,973	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 572,015	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,126	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,126	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	171,529	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 171,529	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,827,933	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,715,789	31
32	Health Care	3,150,511	32
33	General Administration	2,270,642	33
	B. Capital Expense		
34	Ownership	1,974,301	34
	C. Ancillary Expense		
35	Special Cost Centers	506,020	35
36	Provider Participation Fee	128,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,745,378	40
41	**Income before Income Taxes (line 30 minus line 40)****	82,555	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 82,555	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,835	2,118	$ 76,920	$ 36.32	1
2	Assistant Director of Nursing	3,381	3,762	110,472	29.37	2
3	Registered Nurses	26,873	29,565	667,959	22.59	3
4	Licensed Practical Nurses	34,543	37,934	688,606	18.15	4
5	Nurse Aides & Orderlies	115,078	126,435	1,047,041	8.28	5
6	Nurse Aide Trainees	174	174	1,245	7.16	6
7	Licensed Therapist	530	588	14,868	25.29	7
8	Rehab/Therapy Aides	5,821	6,372	100,365	15.75	8
9	Activity Director	1,946	2,462	32,201	13.08	9
10	Activity Assistants	5,222	5,780	47,934	8.29	10
11	Social Service Workers	5,595	6,196	103,935	16.77	11
12	Dietician	3,530	3,792	57,828	15.25	12
13	Food Service Supervisor					13
14	Head Cook	6,072	6,474	48,655	7.52	14
15	Cook Helpers/Assistants	22,135	23,655	164,741	6.96	15
16	Dishwashers					16
17	Maintenance Workers	4,898	5,167	92,539	17.91	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,810	2,080	116,364	55.94	20
21	Assistant Administrator					21
22	Other Administrative	536	573	24,074	42.01	22
23	Office Manager					23
24	Clerical	8,697	9,609	111,279	11.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,973	2,072	39,367	19.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,531	1,531	44,993	29.39	33
34	TOTAL (lines 1 - 33)	252,180	276,339	$ 3,591,386 *	$ 13.00	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 13,611	01-03	35
36	Medical Director	Monthly	21,600	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,989	10-03	39
40	Physical Therapy Consultant	72	3,767	10a-03	40
41	Occupational Therapy Consultant	107	5,349	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	35	10a-03	43
44	Activity Consultant	42	2,444	11-03	44
45	Social Service Consultant	41	2,413	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	263	$ 58,336		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	32	$ 1,070	10-03	50
51	Licensed Practical Nurses	771	23,465	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	803	$ 24,535		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTE | # 0039834 | Report Period Beginning: 01/01/02 | Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wayne Hanik	Administrator	0	$ 90,180
Farhat Sharif	Administrative	0	26,184
Kathy Brander	Dir Reg. Mgmt	0	11,627
Ray Dolan	VP Risk Mgmt.	0	12,447
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 140,438

B. Administrative - Other

Description	Amount
Management Fees - NuCare Service	$ 643,954
Carepath Health Network	58,020
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 701,974

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 32,375
Frost, Ruttenberg & Rothblatt	Accounting	28,564
See Attached	Computer Services	24,713
Personnel Planners	Unemployment Consult.	6,521
Long Term Care Assoc.	IOC Chart Audit	800
Purchasing Plus	Purchasing Clst	900
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 93,873

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,771
Unemployment Compensation Insurance	41,934
FICA Taxes	255,691
Employee Health Insurance	168,598
Employee Meals	17,947
Illinois Municipal Retirement Fund (IMRF)*	
NuCare Payroll Taxes Reimb.	17,873
Chicago Head Tax	6,772
Other Employee Benefits	17,415
401K Plan	2,396
Union Pension	24,708
TOTAL (agree to Schedule V, line 22, col.8)	$ 604,105

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	500
Health Care Worker Background Check	140
(Indicate # of checks performed 14)	
Dues & Subscriptions	10,039
Classified Advertising	8,543
Yellow Page Advertising	3,183
License & Inspections	3,178
Allocation Nucare	1,175
Allocation Carepath	5,346
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(3,183)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,921

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,496
Allocation Nucare	1,289
Allocation Carepath	34
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,819

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number JACKSON SQUARE NURSING & REHAB CENTER # 0039834 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $12,671**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,264** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **128,115**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,947** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees